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Backgrounder

MIDWIFERY: A NEW STATUS

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INTRODUCTION

The practice of midwifery has existed throughout history and in all cultures. Experienced, skilled women have always assisted other women during pregnancy and childbirth, although they did not always make a living from providing these services. It was not until the twentieth century, and only in some western countries, that the process of childbirth was moved from the home to a hospital environment under the control of physicians.

The word "midwife," which comes from Old English and means "with woman," is defined as "a woman skilled in aiding in the delivery of babies."(1) Obstetrics, on the other hand, is defined as "the branch of medicine concerned with childbirth and the treatment of women before and after childbirth."(2) While midwifery views childbirth as a natural creative process, the medical profession tends to treat it as a pathology or illness and increasingly advocates hospital births using the latest medical intervention.(3) Although the "medicalization of childbirth" is essentially a twentieth century phenomenon, the assumption is prevalent in North America that births "delivered" by physicians in hospitals are the only safe ones. As will be shown in this paper, however, the available research from Canada, the United States, Britain and The Netherlands does

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(1) The Collins English Dictionary, London, 1986.

(2) Ibid.

(3) Lisa Jezioranski,"Towards a New Status for the Midwifery Profession in Ontario," McGill Law Journal, Vol. 33, No. 1, 1987, p. 92.

not support this assertion. While infant mortality and maternal death rates have declined in most industrialized countries since the 1930s, this decline cannot be attributed entirely to hospital births or the birthing procedures used by physicians.

Throughout history, midwifery has been almost exclusively dominated by women and to some extent the continuing dispute between doctors and midwives has been a power struggle based on gender differences in philosophies of childbirth. To an even greater extent, however, this dispute is about professional competition. The present Canadian debate over the legalization and regulation of midwifery touches on important policy issues, such as how public health care costs should be controlled, which health practitioners' fees should be covered by Medicare, whether parents have the right to choose childbirth alternatives, and what legal rights should be granted to the fetus. The issue of fetal rights is particularly relevant in the "Baby Voth" case, to be discussed later in this paper.

Midwifery adopts a holistic approach to childbirth, and encourages midwives to devote considerable time and attention to each client throughout pregnancy, birth and the post-partum period. Midwives also support the concept of home births, but with the co-operation of physicians and hospitals for emergency situations. Because Canadian medical associations have adopted the position that home births are dangerous and that only licensed physicians should deliver babies, they have advised their members not to cooperate with midwives. Midwives are not permitted to practise in hospitals without the consent and supervision of doctors, nor are their services included in Medicare. This means that if they practise at all in Canada, they are on the fringes of the legal and health care systems.

Medical associations have opposed both the independent practice of midwifery and home births; they feel that midwives are not adequately trained and would not have the necessary knowledge or technology to deal with medical emergencies alone in the home setting. Both doctors and nurses, however, are willing to permit trained midwives to practise within the hospital setting if they are supervised by doctors and regulated by the College of Nurses. But midwives contend that this would undermine

the basic philosophy behind their profession - that childbirth is a normal, healthy function. Physicians, obstetricians and nurses, they say, are trained to deal with illness.(4)

Due to their ambiguous legal and professional status, midwives may be particularly vulnerable to prosecution under criminal and tort laws. Without professional standards and regulation for midwifery, the courts are likely to use medical standards as the benchmark for assessing negligence. Medical organizations, however, are openly hostile to midwifery and have made policy statements suggesting that the very practice of midwifery is negligent.(5)

A further complication for midwives is that there are three parties involved in childbirth: midwife, mother and fetus. The increasing trend to accord rights to fetuses may encourage greater technological intervention on behalf of the fetus to protect physicians and midwives from tort cases. Although the fetus has not been considered a legal person by the Canadian Charter of Rights and Freedoms, courts have awarded custody of a fetus to a child welfare agency when there were grounds to believe that health and safety were in danger.(6) Recent court cases in the United States relating to the detection of fetal abnormalities have tended to impose on physicians and midwives the duty to use all the latest medical technology to attempt to discover birth defects. The philosophy behind midwifery, however, supports natural childbirth and de-emphasizes interventionist procedures.

Despite the dubious legality of midwifery, it is becoming increasingly acceptable to Canadians as an alternative to medical delivery, which some see as excessively technological, interventionist and

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(4) Linda Hossie, "The Midwives Battle for Self-Rule," Globe and Mail (Toronto), 12 November 1985.

(5) College of Physicians and Surgeons of Ontario, "Nurse-Midwives," College Notices, January 1982.

(6) Jezioranski (1987), p. 114-117.

expensive.(7) In response to lobby groups arguing for a more humanistic birthing environment and with the intention of reducing health care costs, Canadian provincial governments are beginning to re-evaluate the legal and professional status of midwifery, and to consider its integration into the health care system.

HISTORICAL BACKGROUND OF MIDWIFERY IN CANADA

Historically, the community midwife, who was considered to be the expert on childbirth, received her training from a long apprenticeship with an older midwife. From the diaries, letters and records of early European traders, missionaries and settlers, we know that many native groups relied on midwives during childbirth. Medical missionaries were often impressed with the skill of these women, the absence of infection during childbirth and low rates of neonatal mortality. Historical records also indicate that in the early 1700s, midwives trained in France were paid by the French king to practise in New France. The British government also paid an allowance to midwives in Nova Scotia, at least for a brief period during the 1750s. In Nova Scotia and Quebec, the practice of midwifery was legal until after the First World War.(8)

Newfoundland, although not explicitly permitting midwifery, had a long tradition of lay midwives or "granny women" in the villages and outports until the 1960s. In addition to dealing with childbirth and reproductive problems, these women served as lay healers for all community members in times of illness. Midwives also worked in cottage hospitals

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(7) Ibid., p. 90-91.

(8) Task Force on the Implementation of Midwifery in Ontario, Report, Toronto, 1987, p. 199-200.

between 1930 and 1960.(9) Except among particular isolated ethnic groups or in the outports of Newfoundland, however, women whose primary function was midwifery were rare. Instead, farm women assisted their neighbours and relatives during childbirth but seldom accepted money for their services.(10)

As the medical profession became more organized in Upper Canada, opposition to midwifery grew as both doctors and midwives competed for the same patients. In 1795, the government of Upper Canada passed the first Act to Regulate the Practice of Medicine, which made it illegal to practise physic, surgery or midwifery without a licence. Yet the shortage of doctors and enforcement procedures meant that this law was never enforced. In 1815, 1818 and 1827, more Acts were passed, but midwives were exempt until a new law was passed in 1865.

In the 1870s, several attempts were made to license midwives in Upper Canada, but doctors intervened. This did not stop neighbours helping other women with their births, so that doctors found themselves in competition with these women, who provided aid for illness, as well as childbirth.(11)

The first conviction of a midwife charged with practising medicine without a licence was in 1895. This case caused so much public outcry, however, that a sympathetic politician paid the midwife's fine.(12)

In 1897, Lady Aberdeen, of the National Council of Women, created the Victorian Order of Home Helpers, which compounded doctors' fears of competition. Lady Aberdeen wanted the new organization to provide

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(9) Celia Benoit, "Midwives and Healers: The Newfoundland Experience," Healthsharing, Winter 1983; Celia Benoit, "Traditional Midwifery Practice: The Limits of Occupational Autonomy," Canadian Review of Sociology and Anthropology, Vol. 26, No. 4, August 1989, p. 636.

(10) Task Force, Ontario (1987), p. 201-202.

(11) Ibid., p. 208.

(12) Lori Cohen, Greg Heaton and Paul Bunner, "A Victory for Midwives," Alberta Report, 25 July 1988.

training for women in midwifery, first aid, simple nursing, household economy and home sanitation, and wanted to upgrade existing midwives into salaried official health workers. After opposition from both doctors and hospital nurses, the organization was renamed the Victorian Order of Nurses, and used trained nurses exclusively.(13)

At the beginning of the twentieth century, many country doctors learned their delivery skills from local midwives or relied heavily on their knowledge and expertise. In cities and larger towns, however, the medical profession was growing in visibility and strongly advocated hospital births with medical intervention. Prior to medical insurance, however, many families could not afford a doctor's fees or hospital expenses, and relied as much as possible on home remedies or neighbours with expertise in childbirth and other health matters.

In the first four decades of this century, doctors and nurses, both of whose livelihoods were adversely affected by midwives and informal health networks, conducted a public re-education campaign which tried to change women's expectations about childbirth and the safety of the medical birth.(14) In spite of this, various medical investigations early in the twentieth century found that maternal mortality rates were actually higher in areas served by doctors and hospitals than in areas where there was neither a doctor nor a public health nurse.(15) Before the introduction of improved sanitation, hygiene and procedures of disease control, hospitals and medical techniques did not foster improved health; indeed, lack of intervention during the birthing process was often beneficial. Concerns about high rates of maternal mortality in Canadian hospitals during the 1920s led to serious attempts to improve hygiene and disease control. Some doctors even suggested in the Canadian Medical Association Journal that midwifery should be legalized, because mortality rates for home births were lower than for hospital births. But most doctors tended

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(13) Task Force, Ontario (1987), p. 210.

(14) Ibid., p. 212.

(15) Ibid., p. 203.

to blame women themselves for birth problems, claiming that they did not take care of themselves or consult doctors for prenatal care.

By 1937, however, rates of infant and maternal mortality had dropped sharply in Canada. Although this decline has been attributed to the discovery of antibiotics and the enormous increase in hospital births, the decline had begun a year before the introduction of the first antibiotic. Furthermore, European countries also experienced this decline, despite their continued use of midwives and home births.(16) The drop in mortality may have been related to improved living conditions, sanitation, hygiene and nutrition.

In northern and other remote areas of Canada, public health nurses were informally allowed to deliver babies in emergencies, but with the shortage of doctors, nurses became extensively involved in midwifery. As more regional hospitals were built, however, policies were established to evacuate women in labour so that doctors could deliver their babies in the new hospitals. Nurses were not supposed to deliver babies, but in fact did attend the deliveries of women who refused to be evacuated.

As immigration laws prevented European-trained midwives from entering Canada and as non-hospital births became rarer, fewer Canadian-trained nurses felt confident to deliver babies. Although there has been at least one recent experiment using "maternity teams" of native midwives and non-native doctors and nurses, hospital births among strangers have become prevalent for native people living in the north.(17)

By the end of the 1950s, childbirth in Canada was generally viewed as an unnatural event or a form of illness requiring hospitalization and medical intervention. Husbands were not allowed in the labour room, and drugs, forceps and surgery were commonly used in childbirth. Because of increasing costs of liability insurance, exclusion from hospital privileges, technological advances in obstetrics, and a desire for regular hours, many family practitioners stopped delivering babies and allowed

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(16) Ibid., p. 222.

(17) Ibid., p. 226.

specialists to take over. This often meant that there was little continuity in maternal health care.

In recent years, feminists, health reformers, and various consumer groups have been working to reform the birthing process to make it more responsive to women's needs and expectations, to encourage the participation of husbands, and to involve midwives who can provide continuous care for a lower cost than physicians.

Midwives continue to work in Canada, but generally as nurses in hospital obstetric wards or as public health nurses in remote areas. Many are immigrants, who received midwifery training in their homeland but were expected to retrain as nurses when they came to Canada. Most provinces bar the autonomous practice of obstetrics or midwifery by anyone other than licensed physicians.

The dying out of the birth culture involving midwives or knowledgeable neighbours and relatives cannot be adequately explained by the introduction of a safer system. As we previously mentioned, at one time there were indications from some parts of the country that undoctored births were safer than medical births. But the neighbourhood network of mutual aid disappeared with industrialization, modernization, the disapproval of the growing professions of doctors and nurses, and re-education programs by public health nurses.(18)

CROSS-CULTURAL COMPARISONS OF REGULATION AND QUALITY OF CARE

Although midwifery is still practised throughout the world in lay form and is the predominant form of birth care, it can now be legally carried out in most industrialized countries only if the practitioners are licensed or certified.(19) Several European countries

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(18) Ibid., p. 220-227.

(19) Jezioranski (1987), p. 105.

(most notably The Netherlands, Britain, Sweden and Finland) rely extensively on midwives in hospital and home births.

In The Netherlands, the obstetrician/midwife debate was taking place as early as 1880, when it was agreed that home births should be encouraged because they were safer than hospital births. Since then, midwifery has been the predominant form of birth care and midwives attend deliveries without the supervision of physicians. In The Netherlands, 30% of births take place at home, compared to 1% in Britain, Canada and the United States, and Dutch general practitioners and midwives both deliver at home. Like other countries, however, the trend in The Netherlands has been toward hospital births. While 74% of all Dutch births took place at home in 1958, this figure had dropped to 48% by 1974 and 30% by 1984.(20) In the mid-1970s, midwives attended about 67% of home births and over a third of all births.(21)

The Ministry of Public Health in The Netherlands did not establish a policy on the place of birth, as the National Health Service did in Britain. The Dutch health system is based on private insurance, which covers the payment for prenatal care, delivery and postnatal care only if provided by a midwife - not by a physician - as long as a midwife practises in the community and there are no medical indications for specialized care. Health insurance also covers the cost of nursing aides, which makes home birth easier for women. While Dutch midwives are trained in a special program lasting three years, British midwives initially train as nurses, and then take one year of obstetric training.(22)

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(20) Alberto Torres and Michael R. Reich, "The Shift from Home to Institutional Childbirth: A Comparative Study of the United Kingdom and The Netherlands," International Journal of Health Services, Vol. 19, No. 3, 1989, p. 406.

(21) G.J. Kloosterman, "The Dutch System of Home Births," in S. Kitzinger and J.A. Davis, eds., The Place of Birth, Oxford University Press, Toronto, 1978, note 54 and 85.

(22) Torres and Reich (1989), p. 407-410.

In England, midwifery was regulated in 1902 after years of struggle for recognition as a profession. The Midwives Act made it possible for midwives to work as licensed practitioners but vested control of midwifery in the Central Midwives Board, a body composed largely of physicians. Throughout this century, the role of British midwives has continued to shrink as physicians have assumed more of the tasks relating to pregnancy and birth. Over 80% of British midwives work in hospitals, where 99% of births take place, and virtually all midwives are employed by the National Health Service.(23) The centralized planning process of the National Health Service helped facilitate the movement from home to institutional births in the United Kingdom, and ensured that the lobbying efforts of the medical profession had a major and rapid impact on the location of childbirth.(24)

Although midwives are still the senior persons present at three-quarters of all British births, the scope of their clinical judgment narrowed significantly once birth moved to the hospital setting. As employees of hospitals, midwives are subject to hospital regulations concerning birth procedures and these are largely set by obstetricians. Consequently, technological intervention increased considerably during the 1960s and 1970s. At the same time, however, the maternity rights and the feminist movements grew in strength, and objected to much of this intervention.(25) The Association of Radical Midwives was organized in 1976 as a support and study group but eventually became a political action organization to reduce medical intervention in birth, to develop training programs that would not require midwives to train first as nurses, to promote natural and home birth, and to encourage more continuity of care

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(23) Rose Weitz, "English Midwives and the Association of Radical Midwives," Women and Health, Vol. 12, No. 1, 1987, p. 81.

(24) Torres and Reich (1989), p. 409.

(25) Ibid., p. 82.

for pregnant women. Few English midwives, however, consider themselves "radical midwives," seeing themselves rather as maternity nurses.(26)

In the United States, only about 1% of births take place outside hospitals. Of these, midwives attended about 74% or 28,000 births in 1984.(27) A national survey was recently conducted to assess the current status and characteristics of state legislation regulating the practice of lay midwifery. A "lay midwife" is someone who practises in a home setting and who has been trained by apprenticeship. As of July 1987, ten states in the United States explicitly allowed lay midwives to practise, ten states prohibited lay midwifery, five states had "grandmother" clauses authorizing midwives practising under repealed statutes, and five states had enabling laws which had not been used. In the remaining 21 states, the legal status of midwives was unclear. The authors of this study conclude that states with so-called enabling laws have actually restricted the practice of midwifery more than have those states where midwifery has unclear legal status.(28)

In an attempt to compare the safety of midwife-attended births and that of physician deliveries, researchers have turned their attention to rates of infant and maternal mortality as well as to complication rates during the birthing process. The United Nations gathers international statistics both on maternal death rates (caused by deliveries and complications of pregnancy and childbirth) and on infant mortality. Although many factors, such as maternal diet, exercise, lifestyle, personal and professional health care and birthing practices, could affect these death rates, they could provide a rough indication of how health care available to pregnant women in Canada compares with that in other countries. According to the United Nations Demographic Yearbook (1984 and

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(26) Ibid., p. 84.

(27) Irene H. Butter and Bonnie J. Kay, "State Laws and the Practice of Midwifery," American Journal of Public Health, Vol. 78, No. 9, 1988, p. 1167.

(28) Ibid., p. 1161.

1985), Canada's maternal death rate per 100,000 live births was 3.2 in 1984 compared to 8.0 for the U.S.(1983), 8.2 for the U.K.(1984), and 4.5 for The Netherlands (1985). The Canadian infant mortality rate for babies less than one day old was 2.9 per 1,000 live births in 1986 compared to 4.4 for the United States (1985), 2.6 for the United Kingdom (1984) and 2.0 for The Netherlands (1985). These statistics show no consistently different pattern in maternal and early infant death rates between countries with legal midwives (such as U.K. and The Netherlands) and those without (such as Canada and the U.S.). But not all births in countries with legalized midwifery are attended by midwives, and some take place in hospital while others take place at home. The more accurate comparison of statistics would be between midwife-attended births and physician births within each country, but these figures are difficult to find.

In North America, midwives generally attend normal low-risk births and refer cases with complications to medical practitioners. Although this is a general practice among lay midwives, it is a legal requirement for nurse-midwives. The fact that physicians and doctors deal with a greater proportion of high risk births means that rates of neonatal mortality (up to four weeks after birth) are higher for hospital/physician births. Studies which control for risk factors, however, reveal that mortality rates are comparable for both groups of practitioners. In fact, studies which compare the two groups after the introduction of midwifery programs into American hospitals, such as in California in the 1960s, actually show lower neonatal death rates for midwife-attended births than for obstetrician care.(29)

Research comparing rates for Caesarian sections and subsequent complications in midwife births with those in physician births has helped prompt a review of the legal status of midwifery. North American physicians have been criticized in recent years for performing medically unnecessary Caesarian operations. In fact, North American hospitals carry

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(29) Footnote 37, page 100 of Jezioranski's article, lists the references of several studies published in the American Journal of Obstetrics and Gynecology in 1969 and 1971.

out the highest rate of Caesarian sections in the world and in 1988 the American rate had jumped to 25% from about 5% in the 1960s. A study by California researchers, published in 1989 in the New England Journal of Medicine, found that wealthy women in the United States are nearly twice as likely to undergo a Caesarian section as poor women, regardless of age, race, or complications during pregnancy. Caesarians in the United States are particularly likely to be done by private physicians rather than by physicians working in public hospitals or with patients covered by government health care plans.(30) This implies that doctors perform Caesarians on women who can afford to pay for this operation, whether or not they really need it.

In Canada, the Caesarian section rate is about 17 per 100 births, with a high rate of about 20 in Ontario and Quebec, compared to an average of 15 in European countries.(31) The Netherlands, with an above-average percent of home births attended by midwives, had a rate of 6 Caesarians per 100 live births in 1985.(32) In comparison with vaginal births, Caesarian sections are associated with higher rates of maternal and fetal mortality, higher rates of infection and the need for continued medical attention. The extensive use of electronic fetal heart monitors may increase the likelihood of unnecessary medical intervention during labour because studies suggest that such monitors are not accurate predictors of fetal stress. False stress indications increase the likelihood of Caesarian sections which result in greater mortality and morbidity. These monitors also increase the risk of perforations of the uterus and placenta and lacerations to the fetus.(33)

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(30) Globe and Mail (Toronto), 27 July 1989.

(31) Hossie (1985).

(32) Torres and Reich (1989), p. 408.

(33) United States Department of Health, Education and Welfare, Cost and Benefits of Electronic Fetal Monitoring: A Review of the Literature, DHEW Publication No. 79-3245, 1979.

In addition to the issue of the safety of midwife/physician deliveries is the issue of comparative cost. In the Dutch health care system, midwifery is considered the lower-cost form of pregnancy care and health insurance pays for physician care only in higher-risk pregnancies. Several Canadian reports recommending the incorporation of midwives' services into Medicare have suggested that midwives should be salaried and paid about the same as nurses, which is about $25,000 to $35,000 per year, only a fraction of the average income of a family practitioner or obstetrician. Midwives also rely less than physicians on technological monitoring, drugs and other interventions, and there is evidence that midwives' clients require less post-partum care and recovery time. This implies that costs for midwife-attended births could be lower than for hospital births at present.(34)

There is a growing awareness in Canada that the costs of maternity care would be greatly decreased under a system of midwifery practice. Evidence from the United States indicates that Ontario taxpayers could see maternity costs cut in half if normal births were assisted by midwives instead of physicians.(35)

SOME PROVINCIAL INITIATIVES

A. British Columbia

In British Columbia, there are about 300 to 400 home births a year, which is just under 1% of all births. All planned home births are midwife-attended, as the British Columbia College of Physicians and Surgeons does not allow doctors to deliver outside hospitals. According to the president of the Midwives Association of B.C., only 3% of planned home births required hospitalization for forceps or Caesarian-section delivery

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(34) Cathy Fooks and Bob Gardner, "The Implementation of Midwifery in Ontario," Current Issue Paper #50, Ontario Legislative Library, Toronto, 1986, p. 7.

(35) Jezioranski (1987), p. 131.

in 1986. In the same year, such interventions were used in 25% of the births at Vancouver's Grace Hospital, British Columbia's largest maternity centre.(36) Midwifery training is available for British Columbia nurses, but they cannot practise independently without a physician's supervision.

In 1980, an obstetrician at Vancouver's Grace Hospital initiated a pilot project in which six nurse-midwives provide total maternity care, including delivery with a physician present as an observer. After the first 100 patients, the project was reviewed and the results were compared with those from a matched group of low-risk pregnancies cared for by family physicians. The project review was funded by a National Health Fellowship and a portion of the study was published in the Canadian Medical Association Journal in 1988.(37) Using a standardized scale to measure quality of care, adapted and pretested for this particular study, the researchers found that nurse-midwives provided prenatal care to low-risk women that was comparable, if not superior, to the care provided by family physicians; the complication rate for midwife care was no higher, the infection rate was down by 5%, and the forceps and epidural rates were only 10%. Overall, about 19% of all Canadian births are forceps-assisted.(38) Although this program has not been publicized, demand for low-risk maternity care by the Vancouver Grace Hospital midwives has outstripped current capacities.

Although lay-midwifery has been practised in British Columbia for many years, public discussion about the role of midwives in the health care system and the legal status of the fetus reached a peak with the "Baby Voth" case in 1985. Two lay-midwives were convicted of two counts of criminal negligence, one for causing the stillborn death of the

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(36) Cohen et al., (1988).

(37) Lynn Buhler, Ned Glick and Samuel B. Sheps, "Prenatal Care: A Comparative Evaluation of Nurse-Midwives and Family Physicians," Canadian Medical Association Journal, Vol. 139, 1 September 1988.

(38) Eleanor LeBourdais, "Despite CMA Misgivings, Support for Midwifery Appears to be Growing," Canadian Medical Association Journal, Vol. 139, 15 October 1988, p. 770.

fetus they were delivering in a home birth and the other for causing bodily harm to the mother. In October 1986, the midwives were acquitted on the second charge but convicted on the first, and were given suspended sentences and three years' probation. The judge concluded that they had disregarded risk factors that should have ruled out a home birth and had then ignored obvious distress signals. The British Columbia Court of Appeal, however, reversed the conviction of causing death to the fetus, concluding that the fetus was not a "person" but a part of the mother's body. The court then substituted a conviction on the second count.

The "Baby Voth" case is expected to go to the Supreme Court of Canada, where Women's Legal Education and Action Fund (LEAF) will intervene because of the potential implications of this case for all women. LEAF is concerned that the following issues could be addressed by the Supreme Court: a woman's practices of nutrition, contraception, and sexual activity both before and during pregnancy; her right to refuse or accept medical treatment during pregnancy; the nature of her right to seek access to criminal or civil justice in the event of negligent medical treatment; the allocation of decision-making rights between the pregnant woman and the state when prenatal care conflicts arise; and the legal status of a fetus.

The lobby to legalize midwifery appears to be growing in British Columbia, and includes some physicians as well as nurses, midwives and others. In 1987, 37 physicians submitted a letter to the College of Physicians and Surgeons of British Columbia protesting its hard-line interpretation of the Medical Practitioners Act and subsequent move to forbid any form of collaboration between physicians and midwives. The Interdisciplinary Midwifery Task Force of B.C., a registered non-profit society, has had the legalization of midwives as its primary goal since 1980. More than 500 obstetricians, family physicians, nurses, midwives, people who hire midwives and other supporters belong to this group. Both the Task Force and the Midwives Association of British Columbia have been devoted to gaining support for legalization through public education and lobbying. The British Columbia Ministry of Health recently asked the Task

Force to carry out a study of the acceptability of midwifery, with the assistance of a $500,000 federal grant.

B. Alberta

In May 1988, the Alberta Advisory Council on Women's Issues produced a discussion paper on midwifery after concerns about the quality of maternal health care were brought to the attention of the Council. In this report, the debate about current maternal care in Alberta centred on the quality of care, continuity of care, the traditional values of midwifery, and consumer rights. The report did not make any recommendations, however, but simply outlined the point of view of the various participants in the debate.

As of February 1989, there were apparently six practising midwives in Alberta, who last year delivered close to 200 babies. The Alberta Association of Midwives would like to see midwifery legalized and standards created for training. They have suggested a four-year post-secondary course leading to a bachelor's degree, which they feel would protect both the public and midwives.

A consumers group called the Alberta Midwifery Task Force has been lobbying since 1988 to have the government legalize midwifery. On the other hand, the position of the Alberta Medical Association is that midwives should deliver only in a hospital under the supervision of a physician and only after they are "properly" trained and registered.

C. Manitoba

In May 1987, the Manitoba Advisory Council on the Status of Women produced a discussion paper on midwifery which supported its legalization and regulation, the provision of midwifery education programs, and the incorporation of midwifery into Manitoba's health care system.

D. Ontario

In Ontario, no legislation exists for the practice of midwifery as a distinct profession. The Health Disciplines Act states that

no person may practise medicine unless licensed to do so by the Council of the College of Physicians and Surgeons of Ontario, and the practice of medicine is defined to include surgery and obstetrics. The Health Disciplines Act contains two exceptions to practising without a licence: rendering first aid or emergency treatment without a fee and administering household remedies by members of the patient's household. Section 67(2) of the Act makes explicit reference to midwifery, stating that anyone who professes to be qualified or who practises midwifery is guilty of an offence. This suggests that a midwife could conceivably be prosecuted for practising her profession, although this has apparently never happened.

In April 1984, Bill 48 was introduced into the Ontario legislature by New Democratic Party MPP David Cooke. This bill, which would have established midwifery as an independent self-governing health profession, did not progress to a vote because members felt that further studies were needed to assess the impact of regulated midwifery on the health care system. They also wanted to await the results of the Health Disciplines Review Committee, which had been established in 1983 to report on the proposed legalization of several new health disciplines in Ontario.

In 1985, the death of a baby at a birth attended by a midwife on Wards Island in Toronto raised public awareness of midwifery. An Ontario coroner's jury recommended, after lengthy hearings, that midwifery be legally regulated in Ontario, covered by provincial health insurance (OHIP), and be subject to compulsory malpractice insurance. The Health Ministry, however, would not recommend that the practice of midwifery be licensed until the issue had been thoroughly studied.

In 1986, the Health Disciplines Review Committee recommended that midwifery become a legally regulated profession, a recommendation which was accepted by the Health Minister. How to integrate midwives into the existing health care system was to be decided by a Task Force, chaired by Toronto lawyer Mary Eberts. Although the Task Force included a lawyer, a doctor, a member of the previous Health Disciplines Review Committee and a nurse, it did not include a midwife.

In October 1987, the Report of the Task Force on Midwifery recommended the training and licensing of midwives as independent

professionals (rather than as practitioners requiring physician supervision or as members of the nursing profession). According to the report, midwives should be educated in a four-year university program which would not require a nursing certificate as a prerequisite. The establishment of such a program would probably cost about the same as a nursing program, which is about one-third of the cost of medical training.(39) The Task Force also recommended the establishment of a college of midwifery to regulate the profession and a series of safeguards to ensure the highest standards of practice. The report noted that there is now enough evidence to suggest that young, healthy women whose pregnancies proceed normally run no extra risks by giving birth at home. If midwives were licensed and incorporated into the existing medical system, they would be able to arrange in advance for emergency backup care in case of home birth problems.

In response to this report, Ontario Health Minister Elinor Caplan appointed a council of 13 health-care experts to set standards of practice and certification requirements for midwives. This council, which will be led by lawyer Mary Eberts, who chaired the Midwifery Task Force, is expected to pave the way for new legislation in 1990 that will formally regulate the profession and establish a College of Midwives, similar to the colleges that exist for doctors and nurses.(40)

In 1989 there were about 50 practising midwives in Ontario who had delivered roughly 3,000 babies in the past five years. Because midwives are not regulated, they cannot obtain accident insurance. They rely on voluntary guidelines covering agreements with clients, equipment and procedures laid down by the 125-member Association of Ontario Midwives. Their fees, which are not covered by provincial health insurance, average about $800 for prenatal and postnatal care as well as attendance at labour and delivery. Most Ontario midwives operate on a sliding scale,

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(39) Fooks and Gardner (1986), p. 6.

(40) Christie McLaren, "Midwives Move Closer to Recognition," Globe and Mail (Toronto), 5 July 1989.

charging less for clients with lower incomes. If midwifery becomes an insured benefit under provincial health insurance plans, this sliding scale would probably be replaced by a flat fee. Contrary to the Task Force recommendation for a four-year university course, the Association of Ontario Midwives feels that a three-year course would suffice.(41)

E. Quebec

The medical Act in Quebec prohibits anyone other than a licensed physician from practising obstetrics. Despite the dubious legal status of midwifery in Quebec, there are about 20 to 30 practising midwives who belong to Quebec Alliance of Practising Midwives or l'Association des sages-femmes diplomées du Québec. In remote northern areas, for example, midwives often deliver babies because of the shortage of physicians. Even in urban hospitals, some doctors who favour the legalization of midwifery have been allowing midwives, who are permitted to assist physicians, to deliver babies. In April 1989, however, administrators of a Montreal hospital suspended a physician for six months for allowing a midwife to deliver the baby, yet another Montreal hospital interested in starting a midwifery pilot project immediately offered him a position.(42)

There used to be an obstetrics course at Laval University for nurses planning to practise outside Quebec or in the north. According to several newspaper articles, the course was dropped in 1972 when women asked to be allowed to practise inside Quebec.(43)

Over the past decade, several organizations have been promoting natural births and the de-medicalization of childbirth. These organizations, such as Naissance-Renaissance, have used official statistics to show the increasing use of medical intervention in childbirth. They have

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(41) Ibid.

(42) Kate Dunn, "Midwives: Operating on Law's Edge," The Gazette (Montreal), 15 April 1989; Michèle Ouimet, "Ces sages-femmes dont on parle tant," La Presse, 13 May 1989.

(43) Ibid.

reported, for example, that 82% of women giving birth in Quebec were given episiotomies in 1979 and in 1982 18% had Caesarian sections (up from 12% in 1977). Advocates of the legalization of midwifery claim that these medical interventions are frequently unnecessary yet they often result in a requirement for further medical attention. Naissance-Renaissance is working hard to promote the legalization of midwifery and the development of autonomous birthing centres separate from hospitals, where giving birth can be less bureaucratic and the family can be present.(44)

In 1988, the Commission of Inquiry into Health and Social Services, Quebec (known as the Rochon Commission) recommended that midwifery be legally recognized. In addition, the Advisory Council on Social Affairs in January 1988 urged the government to set up a three-year pilot project using midwives for some low-risk births. The Provincial Task Force on Midwifery also recommended that midwives be regulated. In March 1989, the Minister of Health and Social Services, Thérèse Lavoie-Roux, announced her intention to allow midwives to practise in some hospitals on an experimental basis. Initially, she stated that she would wait for approval from the medical association before introducing legislation, but in May 1989 it was made clear that medical opposition would not diminish.

Quebec doctors reacted angrily to the proposal to legalize midwifery. When Dr. Augustin Roy, president of the Quebec Corporation of Physicians was interviewed by the press, he was alleged to have said: "Why not legalize prostitution? There are a lot more people asking for the legalization of prostitution than the legalization of midwives?"(45) Clement Richer, president of the Quebec Federation of General Practitioners was quoted as saying that allowing midwives to deliver babies is "like

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(44) Marie-Claude Martel, "Où Accoucher," The Canadian Nurse, April 1988, p. 37.

(45) Ingrid Peritz, "Quebec Wants Midwives Law by June," The Gazette (Montreal), 10 May 1989.

letting an apprentice pilot take charge of a Boeing 747 loaded with passengers."(46)

A bill to legalize midwifery in a limited number of pilot projects in Quebec hospitals was introduced into the legislature in June 1989, two days before the summer recess. Quebec doctors have threatened to boycott the projects, which cannot succeed without their cooperation. Furthermore, the summer recess and the Quebec election will likely cause the bill to be delayed or dropped.

F. Newfoundland

While midwifery was eliminated throughout North America with medical bureaucratization, medical dominance of maternity care and the move to hospital births, it was merely transformed in Newfoundland and Labrador. Lay midwives, who had learned their skills through apprenticeship, used to deliver babies at home as well as tending to other sick people, sometimes for a small fee or for vegetables, depending on the family's means. In the 1930s these midwives and other interested women were offered three-month courses to work as government employees in the new "cottage hospitals," which employed five to ten trained midwives in each maternity ward. The cottage hospitals were in many ways an improvement for the autonomous lay practitioners because they provided a steady income, a constant place of work, a division of labour, and back-up medical services and facilities with relative freedom from supervision. Regionalization of maternity care began in the 1960s, however, and many of the cottage hospitals were closed. Only a few nurse/midwives are now employed by large regional hospitals, but these work under the supervision of hospital administrators and medical specialists.(47)

Newfoundland's Midwifery Act, revised in 1970, states that the practice of midwifery is to be controlled by the Newfoundland Midwifery

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(46) André Picard, "Quebec Doctors Denounce Proposed Midwifery Law," Globe and Mail (Toronto), 11 May 1989.

(47) Benoit (1989).

Board. The Board regulates the certification of midwives, issues licences to practise and regulates the areas in which a midwife may work. The Board has been inoperative for about 27 years, however, and officials in the Newfoundland Department of Health consider the Midwifery Act to be obsolete. In 1987, there was an attempt to repeal the Act, but the Alliance of Nurses and Midwives protested.

Those midwives who still practise in Newfoundland are trained nurses; they provide prenatal and postnatal counselling and support during the birth, but they do not deliver babies. With no medical backup, they are unwilling to risk home births. This means that in isolated regions, women in the latter stages of pregnancy must travel to a hospital to await labour, causing hardships for themselves and their families. The movement for independent midwifery in Newfoundland appears to be growing but is not strong enough to challenge the Act.(48)

CONCLUSIONS

Canadian midwives work without the benefit of a regulatory college, recognized training, legal protection or assurance of payment. Because they practise outside Medicare, their fees (about $800 for prenatal, birth and postnatal care) are beyond the means of the poor. In the absence of educational requirements and standards, it is possible in theory for anyone to work as a lay midwife outside a hospital setting. Provincial laws in most provinces restrict the delivery of babies to physicians, however, and the lack of support from hospitals and the medical profession make the practice of midwifery difficult.

Many Canadian midwives received their training during their nursing education in Europe while others trained as lay midwives or nurse-midwives in the United States. Although there is increasing demand

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(48) Deborah Redfern, "Midwifery in Newfoundland," Healthsharing, Winter 1987, p. 9.

for midwifery courses and the regulation of the profession in Canada, opposition has come from both physicians and hospital nurses.

In 1987, the Canadian Medical Association Journal (Vol. 136, 15 June 1987) printed a statement about the role of midwives. This clearly stated that the Association did not support the establishment of midwifery as an autonomous health care profession but believed that nurses could be trained to assume more obstetrical care responsibilities under the direction of physicians. Their own study of obstetrical care concluded that the present system contains all the resources and personnel required to provide Canadian women with the highest quality of obstetrical care.

At a time when health expenditures are under scrutiny and governments and hospitals are searching for ways to cut costs, more extensive use of midwives is being seriously considered in some provinces. Furthermore, Canadian women are increasingly demanding an alternative to the "medicalization" of childbirth and to hospital deliveries by obstetricians. Those who can afford the services of foreign-trained midwives can go outside the medicare system and pay extra for this service. Many trained midwives, however, will not practise in Canada because they fear prosecution, lack liability insurance, or feel they need the support of doctors and hospitals in case of emergency.

There is still considerable disagreement about how the profession should be regulated. Both doctors' and nurses' associations have suggested that the College of Nurses regulate nurse/midwives; yet many midwives feel that if they had to work in hospitals under the authority of doctors and nurses, their philosophy of childbirth would be undermined and the legalization and regulation of midwifery would place the profession under even more severe restrictions than it faces at present.

If midwifery were legalized, if a separate college of midwifery were to set standards of education and practice, if training courses were established and midwifery services were covered by Medicare, the issue of medical cooperation would still remain. Unless physicians were willing to establish a division of labour and share maternity care with midwives, legalization and regulation would not be meaningful. The need

for midwives to obtain physicians' cooperation without jeopardizing their own principles is a dilemma similar to that which has been faced by osteopaths, pharmacists, chiropractors and chiropodists. As long as physicians retain their current dominant role in the health care system, any changes to this system will come on physicians' terms.(49) Yet if midwifery services were incorporated under Medicare, and midwives were permitted to provide prenatal and postnatal care as well as attend low-risk births at home and in hospitals, a considerable number of health care dollars could be saved.

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(49) Deborah A. Sullivan and Rose Weitz, Labor Pains. Modern Midwives and Home Births, Yale University Press, New Haven, 1988, p. 164-165.

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